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ABSTRACT

Alcoholism is frequently called a family disease; encouraging and even insisting that family members participate in the treatment of alcoholics has become routine practice in almost every treatment setting. This study examined the relationship between treatment participation by a family member and two measures of recovery for three birth cohorts of women (N=99) in non-residential treatment for alchoholism. Recovery variables included a self-report measure on psychosocial aspects of their recovery by the women themselves and a therapist rating scale based on individual treatment goals. Results showed approximately 40 percent of the women had a family member who had participated with them in at least one treatment session. There were differences among the cohorts in the types of relatives participating in treatment. Parents were the predominant family members participating in the treatment of the youngest cohort, while spouses and grown children were in the majority for the oldest cohort, and the middle cohort had all three in roughly equal proportions. Data showed that participation in treatment by a family member was positively related to both recovery measures (therapist's rating and self-report of psychosocial recovery) for the oldest cohort of women, aged 46-66, but not for the two younger cohorts, aged 31-45 and 19-30. This positive relationship was found regardless of length of time in treatment, type of treatment program, or level of severity of alcoholism at the beginning of treatment. (Author/ABL)

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THE ROLE OF FAMILY MEMBERS IN THE TREATMENT OF WOMEN ALCOHOLICS

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ABSTRACT

This study explores the relationship between two measures of recovery and participation in treatment by a family member for three birth cohorts of women (total n = 99) in non-residential treatment for alcoholism. It was found that approximately 40% of the women had a family member who had participated with them in at least one treatment session. There were differences among the cohorts in the types of relatives participating in treatment. Parents were the predominant family members participating in the treatment of the youngest cohort, while spouses and grown children were in the majority for the oldest cohort, and the middle cohort had all three in roughly equal proportions. The data show that participation in treatment by a family member is positively related to both recovery measures (therapist's rating and self-report of psycho-social recovery) for the older cohort of women, aged 46 - 66, but not for the two younger cohorts, aged 31 - 45 and 19 - 30. This positive relationship obtains regardless of length of time in treatment, type of treatment program, or level of severity of alcoholism at the beginning of treatment.

INTRODUCTION

Alcoholism is frequently called a family disease (Steinglass, 1976; Jacobs et al, 1978; Baily, 1968). The family disease concept of alcoholism is widely, almost universally, accepted by clinicians. Encouraging and even insisting that family members participate in the treatment of alcoholics has become routine practice in almost every treatment setting. (Steinglass, 1976, 1977; Janzen, 1978). Gerard and Sanger (1966) claim that even one clinic contact with family members can improve the outcome of treatment for an alcoholic.

Several studies have found that where wives participate in male alcoholics treatment, chances of husbands' recovery is greater. Wright and Scott (1978) found that if wives participated in one or more types of treatment or attended Al-Anon, the chances of husbands' abstinence was substantially greater. Corder, Corder, and Laidlow (1972) studied 40 married male alcoholic inpatients, 20 of whom were assigned a program which included wives. Six months after treatment, eight of the 20 controls were abstinent while 17 of the 20 special program patients were abstinent ($p < .05$). Cadogen (1973) randomly assigned 20 married alcoholic inpatients to post-treatment marital therapy and assigned 20 others to a waiting list for marital therapy. Six months later, the control group had fewer abstinent patients ($p < .05$). In a study of 32 married male alcoholic outpatients, Ewing, Long and Wenzel (1961) found that those whose wives attended a concurrent group therapy were more likely to be "abstinent or much improved" at three year follow-up. Smith (1969) studied 23 married

male alcoholic inpatients who attended an aftercare group. Those whose wives attended a concurrent group were doing better (i.e. drinking less or abstinent) at six month follow-up than those whose wives did not attend. However, no studies have explored family participation in the treatment of female alcoholics. Using a multivariate approach, this study will explore the relationship between treatment participation by a family member and two measures of recovery for a sample of 99 female alcoholics in two types of non-residential treatment in upstate New York. It is hypothesized that there will be a positive relationship between recovery and participation in treatment by a family member regardless of the length of time the woman has been in treatment, the type of treatment program she has attended, and her level of severity of alcoholism when she entered treatment.

METHOD

The sample for this study was 99 women in non-residential treatment for alcoholism from five different clinics in upstate New York. Seventy-seven were in a day treatment program where they attended 3 - 5 days per week. Twenty-two were in outpatient treatment where they attended once or twice a week for an hour of therapy. The women were between the ages of 19 and 66 (md. 36) and had been in treatment between one month and one year. The data were collected via a semi-structured, face to face interview combined with a standardized, self-administered questionnaire. All women who were attending the clinics at any time during the period from 5/80 - 3/82 were asked to participate in the study. An informed consent procedure was used whereby the general purpose of the study was explained verbally and in writing to each respondent, she was given an opportunity to ask questions, and then if she wished to participate, she gave her consent in writing.

For the analysis, the women were divided into three birth cohorts, and the data from each cohort was analyzed separately. Cohort 1 (n = 32) consisted of ages 19 - 30, cohort 2 (n = 41) was ages 31 - 45, and cohort 3 (n = 26) was ages 46 - 66. It was believed that the three cohorts would behave differently in keeping with Ryder's (1965) argument that variance on any particular variable is often explained differently for different birth cohorts. The idea of age differences in the alcoholic population is fairly new. In a recent exploratory study, Comberg (1983) found some interesting age differences in a sample of male alcoholic veterans. Considering the rapidly changing roles of women, age can be seen as a very important variable when studying alcoholic women.

A simple model was constructed to test the hypothesis that participation in treatment by a family member is associated with better recovery as measured by two recovery measures. The three birth cohorts of women were each fit separately to the model. A regression equation was used to illustrate the relationship between treatment participation and the two recovery variables after removing the effects of other likely sources of variance in the recovery measures. The model includes four variables in addition to the two recovery variables. The first three variables represent the other likely sources of variance in recovery that need to be controlled for. The fourth is treatment participation.

Level of severity of alcoholism at beginning of treatment, as measured by the Alcohol Use Inventory Global Scale is the first control variable. (Wanberg, Horn and associates 1969, 1970, 1977). Level of severity at beginning of treatment has been shown in the literature to be a powerful predictor of treatment outcome. Bromet, Moos, Bliss and Wuthmann (1977), Gerard & Sanger (1969), McCance & McCance (1969), Ruggels, Armor, Polich, Mothershead & Steven (1975) all found that level of impairment at the beginning of treatment accounted for a substantial portion of the variance in as many as eight different outcome measures. Therefore, it is important that any model attempting to predict recovery should contain a measure of the severity of the problem when the respondent presented for treatment.

Next, the length of time in treatment (in months) was also included in the model. This was included in the model as a statistical control, because the women in the sample had been in treatment for varying lengths of time.

Next, the type of treatment program (day treatment or out-patient treatment) was included to control for possible differences in recovery due to differences in type of treatment program attended. Finally, treatment participation was included as the main independent variable of interest. Treatment participation was defined as a family member attending at least one treatment session with the respondent. It was coded as a nominal variable - yes or no.

The two recovery variables were defined as follows:

Self Report Recovery Score

The women were asked 10 questions regarding psycho-social aspects of their recovery. They were asked to answer the questions first in terms of the month before the interview (Recovery Score II). Then later in the interview schedule they were asked to answer the questions in terms of the month before they entered treatment (Recovery Score I).

The 10 items were taken from 2 different sources and have been shown to be correlated with better adjustment ratings at follow-up in 2 different studies (Foster, Horn & Wanberg, 1972; Bromet, Moos, Bliss & Wuthman, 1977). The items refer to contact with family, hospitalization, use of tranquilizers, suicidal thoughts or attempts, hours of daily T.V. watching, participation in athletic events, community activities, and cultural or sporting events, feeling depressed, and reading the daily newspaper. The scores were devised by assigning a point for each positive answer, adding the scores for I and II separately, and subtracting I from II

Therapist's Rating Scale

Each clinic where data were collected had treatment plans for each of its clients. These treatment plans were individualized goals for each client. Most of these included abstinence, but other goals were included also, depending on the specific woman's problems and her level of functioning when she came to treatment. The Therapist's Rating Scale is a simple 10 point scale on which the therapist was asked to rate the client on how well that client was progressing towards her treatment goals. The scale goes from 1 (not at all improved) to 10 (very much improved). The ratings were done on the day of the interview by each woman's primary therapist.

It was found that 39% of the women in the sample had a family member who had participated with them on at least one treatment session (See Table 1) Twenty-one percent of all participating family members were spouses, 28% were parents, 18% were children, 15% were close friends, and 10% were siblings. In addition, one woman had a former spouse participating and two women had professionals from other agencies participating. (See Table 2)

The proportion of respondants who had family members participating was roughly similar across birth cohorts. The cohorts differed somewhat in the catagories of family members participating. Women in cohort 1 had parents but no spouses or children participating. Women in cohort 2 had parents, children and spouses participating. Women in cohort 3 had spouses and children, but no parents participating.

In the regression solution used for this analysis, the level of severity was entered into the regression equation first, followed by the two treatment factor variables - length of time in treatment and treatment program. Finally, treatment participation was entered. Therefore, the solution shows the amount of variance accounted for by treatment participation after removing the effects of the other three variables. There are six regression solutions in this analysis, one for each of the three cohorts on both recovery variables. Tables 3 and 4 present the beta weights for each of the four independent variables in each solution, as well as the proportion of residual variance explained by treatment participation, and the total amount of variance explained by each equation (R^2).

The equations for all three cohorts on both recovery variables will be discussed together. Table 3 presents the results for the therapist's rating score. Twenty-one and six tenths percent (21.6%) of the variance in the therapist's rating was explained by the four independent variables for cohort 1. Treatment participation explained only 3.2% of the residual variance after removing the effects of severity, time in treatment, and treatment program. The beta was - .19.

Fourteen percent (14%) of variance in therapist's rating was explained by the four variables for the middle cohort. Treatment participation explained only 1.7% of the variance and had beta of .14.

For the older cohort, treatment participation was clearly a strong predictor of therapist's rating, explaining 30.6% of the residual variance. Forty-three and six tenths percent of the total variance in therapist's rating was explained by the four independent variables combined. The beta for treatment participation was .60, which was significant at the .05 level.

The three cohorts' regression solutions for therapist's rating were quite different from each other. Treatment participation was shown to have a positive effect and to explain a large portion of the variance in therapist's rating for the older cohort. Treatment participation had a weak, negative effect on therapist's rating for the youngest cohort and an even weaker but positive effect for the youngest cohort and an even weaker but positive effect for the middle cohort.

The equations for the three cohorts on self-report of recovery show a similar pattern to that of the equations for therapist's rating. (See Table 4) The only large effect for treatment participation was shown in the oldest cohort, where treatment participation explained 25.6% of a total of 56% explained variance. The beta was .55 and it is statistically significant at the .05 level. Again, the beta for treatment participation is negative for the youngest cohort (-.31). Treatment participation explains 8.2% of the 30.5% variance explained for the youngest cohort. Treatment participation explained no variance at all for the middle cohort.[1]

The relatively small number of cases in each cohort places a limitation on the interpretation of these equations. The findings in which the most confidence can be placed is that treatment participation has a positive effect on both recovery measures for the oldest cohort. This is consistent with the results in the literature for men and confirms the hypothesis. The hypothesis is not confirmed for the middle cohort. For the younger cohort, the hypothesis is not only confirmed, but there seems to be a slight trend for treatment participation to have the opposite of the expected effect.

SUMMARY AND DISCUSSION

This study has explored the relationship between two measures of recovery and participation in treatment by a family member for three birth cohorts of women in non-residential treatment for alcoholism. It was found that approximately 40% of the women had a family member who had participated with them in at least one treatment session. There were differences among the cohorts in the types of relatives participating in treatment. Parents were the predominant family members participating in the treatment of the youngest cohort, while spouses and grown children were in the majority for the oldest cohort, and the middle cohort had all three in roughly equal proportions. The data show that participation in treatment by a family member is positively related to both recovery measures (therapist's rating and self-report of psycho-social recovery) for the older cohort of women, aged 46 - 66, but not for the two younger cohorts, aged 31 - 45 and 19 - 30. This positive relationship obtains regardless of length of time in treatment, type of treatment program, or level of severity of alcoholism at the beginning of treatment.

There may be many reasons for the finding that the relationship between recovery and treatment participation is positive for older women, but not for younger women. One possibility is that issues of separation and independence pervade the relationships of younger alcoholic women to their families of origin.

During young adulthood, separation from the family of origin is the common norm in this society. Bardwick (1980) points out that individuation is the major focus in adolescence and young adulthood.

The emphasis is on separating from the family and finding one's own identity, and this may involve areas of conflict with parents and other family of origin members. At older stages, however, family of origin members may become main avenues of support, assistance, and emotional closeness. (Candy, 1980) Even if parents play a role of assistance and support for the younger women in the present study, there may be tension between this necessary function and the process of separation which may be going on simultaneously. None of the young women in the present study made negative comments about their family of origin members who were participating in their treatment (mothers, sisters, and fathers). But many did express uneasiness about accepting aid (both emotional and material) from these family members. A common feeling expressed was "I'm grateful for all they've done, but I need to know I can make it on my own." For many of these young women, alcohol problems have delayed and hampered the separation process and increased their dependency on their family of origin.

On the other hand, many of the women in the youngest cohort who did not have a family member in treatment reported serious conflicts and considerable alienation from parents and siblings and, in some cases, had no contact at all with their families of origin. This group generally reported two scenarios - either the conflicts and/or lack of contact was initiated by the family, who were alienated by the behavior of the respondent while she was drinking, or the respondent initiated the conflicts and/or lack of contact because the family members were alcoholic themselves and did not accept the respondent's new sobriety. In these cases, the respondent considered the lack of contact with family members as positive, since contact with drinking

relatives was viewed as a danger to her sobriety. Even in some cases where alcoholism in the family was not a problem, if family contact resulted in conflict, the respondent felt that staying away was a better option. In some cases, families who were alienated by extreme behavior while the respondent was drinking, continued to view her in a negative light although the respondent was now sober. This tended to happen in cases where the respondent's behavior while drinking was very extreme or where she had tried several times before to sober up. In these cases, the respondents expressed a desire to remain sober "for myself - not to please my mom or anyone else." Most of these women also tended to stay away from their families of origin. While these scenarios cannot be described as positive, the cases where conflicts and/or lack of contact with family members occurred are consistent with the basic task of young adulthood, namely, separation. It is possible that the tension between the need for support in the treatment process and the need for individuation from the family of origin has created a situation where the young women who have a family member in treatment with them do no better than those who do not, and some even do worse.

In the case of the older women, treatment participation clearly has a positive relationship with treatment outcome. The relationships of these women to their family members are also affected by their stage in the life cycle. Presumably, older women would not have the same kinds of separation issues that younger women would and perhaps for this reason are more able to benefit from the participation of family members in their treatment.

The numbers of women in each of these situations are very small, precluding empirical testing with this data of some of the ideas in the previous argument. Nevertheless, the idea of differences in effectiveness of family participation in treatment for different birth cohorts of women is a promising future direction in the investigation of this area. Indeed, this study alerts us in general to the importance of age as a variable in studying alcoholic women.

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FOOTNOTES

1. The F value was .006, which was below the regression program's minimum criterion for including the variable in the equation.

Table 1

Proportion of Respondents with a Family Member Participating in Their Treatment for Three Birth Cohorts of Recovering Alcoholic Women in non Residential Treatment

	Cohort 1		Cohort 2		Cohort 3		All Women	
	n	%	n	%	n	%	n	%
Had Treatment Participation	12	38	17	41	10	38	39	39
Did Not Have Treatment Participation	20	62	24	59	16	62	60	60
Total	32	100	41	100	26	100	99	100

Table 2

Categories of Family Members Participating in Treatment with Three Birth Cohorts of Recovering Alcoholic Women in non Residential Treatment

Respondent's Family Members	Cohort 1		Cohort 2		Cohort 3		All Women	
	n	%	n	%	n	%	n	%
spouse	0	00	4	24	4	40	8	21
former spouse	1	8	0	00	0	00	1	3
parents	7	58	4	24	0	00	11	28
children	0	00	3	18	4	40	7	18
siblings	1	8	2	12	1	10	4	10
close female friend	0	00	2	12	0	00	2	5
close male friend	2	17	1	6	1	10	4	10
professional	1	8	1	6	0	00	2	5
total respondents who had treatment participation	12	100	17	100	10	100	39	100

Table 3

Beta Weights of Four Independent Variables and Proportion of Variance in Therapist's Rating Explained for Three Birth Cohorts of Recovering Alcoholic Women in Non-residential Treatment

	Cohort 1 n=27		Cohort 2 n=38		Cohort 3 n=22	
	beta	% variance explained	beta	% variance explained	beta	% variance explained
Level of Severity at Intake	.36	11.9%	-.17	1%	.14	6.5%
Time in Treatment (in months)	.16	3.4%	.29	11.3%	-.35	6.2%
Type of Treatment Program[2]	-.21	3.1%	-.02	00%	-.13	.3%
Treatment Participation	-.19	3.2%	.14	1.7%	.60[1]	30.6%
R^2	-	21.6%	-	14%		43.6%

1. Significant at the .05 level

2. This variable was coded 1 = outpatient, 2 = day treatment

Table 4

Beta Weights of Four Independent Variables and Proportion of Variance in Self-report of Recovery Explained for Three Birth Cohorts of Recovering Alcoholic Women in Non-residential Treatment

	Cohort 1 n=27		Cohort 2 n=38		Cohort 3 n=22	
	beta	% variance explained	beta	% variance explained	beta	% variance explained
Level of Severity at Intake	.31	7.2%	.21	5.7%	.30	18.4%
Time in Treatment (in months)	.37	14.6%	.21	3.8%	.18	11%
Type of Treatment Program[2]	.02	.5%	.10	1%	.003	1%
Treatment Participation	-.31	8.2%	00	00%	.55[1]	25.6%
R^2	-	30.5%	-	10.5%	-	56%

1. Significant at the .05 level

2. This variable was coded 1 = outpatient, 2= day treatment